Accessibility Services Office Use Only

Date Submitted:_____

Referred to:_____

Appointment Date:_____

Accessibility Services
3377 Bayview Avenue,
Toronto, Ontario, M2M 3S4
Phone: 416-226-6620 Fax: 416-619-1203
Email: accessibilityservice@tyndale.ca

DISABILITY ASSESSMENT DOCUMENTATION FORM

Alternate format of this form is available by contacting the Accessibility Office

Tyndale University is committed to creating an environment where students with disabilities are able to participate and integrate into its strong community. The Student Accessibility Office ensures students are provided appropriate and reasonable accommodations based on the functional limitations of their disability so they can have an equal access to their education while at Tyndale.

The goal of the Student Accessibility Office is to provide students with disabilities a safe and comfortable environment where services are offered that respect their dignity and confidentiality while offering individualized accommodations so they can fully participate in their learning.

This form will be used by Accessibility Services to verify a student has a disability, and/or to understand the impact of the disability and any resultant academic restrictions it places on the student. To receive support from Accessibility Services a student must "communicate his or her needs in sufficient detail and cooperate in consultations to enable the person responsible for accommodation to respond to the request." (Ontario Human Rights Code (OHRC) Guidelines, 1994, p.17). The OHRC Guidelines (1994) also states that the University, as the body responsible for accommodating, must have sufficient information "to properly assess the impact of the disability on the specific academic task and know how to make the requested accommodation."

This form must be based on a current and thorough assessment from an appropriate registered practitioner who is qualified to diagnose the condition (e.g. specialist, psychiatrist, psychologist, etc.)

The provision of supplementary documentation service providers (e.g. health or educational) is also welcome.

Protection of Privacy: In accordance with Section 39(2) of the Freedom of Information and Protection of Privacy Act, 1990 ("FIPPA"), the information on this form is collected under the authority of the Tyndale University College & Seminary Privacy Policy, 2008 for the purpose of determining a need for academic accommodation. All personal information collected will be used, stored, and destroyed in accordance with Tyndale's Records Retention Policy. If you have questions about the collection, use, and disclosure of this information by Tyndale please contact the Accessibility Services Office: 416-226-6620, ext.2189 email: accessibilityservice@tyndale.ca

***For a Learning Disability, ADHD and/or Autism Spectrum Disorder diagnosis**, a valid and recent psycho-educational assessment must be provided.

Student's Name: _____ *Tyndale Student #* _____

SECTION 1 - STUDENT TO COMPLETE:

Consistent with the Ontario Human Right's Commission (OHRC) Policy, students are not required to disclose their disability diagnosis in order to register with the Accessibility Office and access these services (Guidelines On Accessible Education, 2004, p. 20). However, the OHRC also recognizes that the Accessibility Offices have expertise in supporting students with disabilities and disclosing information can promote the planning and implementation of individual accommodation plans – students can choose to disclose information to the office.

Please note: A diagnosis is currently required in order to establish eligibility for certain federal and provincial bursaries and/or grants

If you wish to voluntarily disclose your diagnosis please complete the following:

☐ I consent to disclose the diagnosis of my disability

☐ Are you receiving provincial or federal financial assistance (i.e. OSAP)?

☐ ***OPTIONAL:*** I, hereby authorize the health practitioner to provide the information contained in this form to the Centre for Academic Excellence, Accessibility Services at Tyndale University College & Seminary and, if required, to supply additional information relating to my disability related services. I also authorize the Accessibility Specialist to contact the health care practitioner to discuss the provision of academic accommodations.

Reciprocal Release of Information

While the Accessibility Office will not release specific information about a student's disability, they will verify that the appropriate disability documentation is one file and communicate with the faculty/staff only information pertaining to required accommodations.

By signing this a student can provide authorization to the Accessibility Specialist to share, as needed, more specific detailed information regarding their disability with Tyndale University College & Seminary personnel who have legitimate need to know in order to provide appropriate accommodations and/or services.

This may include:

Faculty, Program Chair, Faculty Advisor, Dean of Student Life, Academic Dean, Centre for Academic Excellence, Office of the Registrar, Student Financial Services, Residence Life Director, or other administrators.

_____***Initial***

I authorize the Accessibility Specialist to discuss information regarding my disability, accommodations, and general progress with:

Parents and Guardians *(list names):* _____ _____***Initial***

Tyndale Counselling Services and/or other relevant Health Care Professional _____***Initial***

I understand that I can amend, change or cancel any or all parts of this release at any time through written notice with the Accessibility Specialist.

Signature:_____ Date:_____

Student's Name: _____Tyndale Student # _____

Student Information

1. Do you require accommodations of any kind to participate in intake interviews, consultations, etc.? ☐ Yes ☐ No

   a. If yes, please indicate the type of accommodation: _____

2. What assistance (academic, financial, etc.) are you seeking from the Accessibility Office?

   _____

3. Have you accessed accommodations before? ☐ Yes ☐ No

   If yes, please list the accommodations: _____

   _____

4. How does your disability/ies impact your academic functioning? *(please check the appropriate options)*

☐ Difficulty attending class	☐ Anxiety/Stress during tests/exams	☐ Concentration
☐ Paying attention in class	☐ Completing assignments on time	☐ Memory
☐ Research	☐ Hearing	☐ Oral presentations
☐ Seeing at a distance	☐ Studying	☐ Reading
☐ Taking notes	☐ Understanding oral language	☐ Writing

   ☐ Other *(please specify):* _____

   _____

5. What strategies do you use to manage the impact of your disability/ies? *(please check as applicable)*

☐ Assistive/Adaptive Technology	☐ Equipment	☐ Physical Rehab
☐ Academic Strategies	☐ Exercise	☐ Tutoring
☐ Counselling/Therapy	☐ Medication	☐ Other *(please specify):* _____

6. Do you use any assistive devices or equipment? ☐ Yes ☐ No

   If yes, please specify: _____

   _____

7. What are your career or academic goals? _____

   _____

SECTION 2 – PRACTITIONER TO COMPLETE

Note to registered practitioner: Tyndale's Accessibility Services facilitates the provision of academic accommodation and supports for students with disabilities. To determine appropriate accommodations, we must confirm and learn about the individual's disability and related challenges as they apply to post-secondary academics. This student is required to provide Tyndale with documentation that is:

- Based on a current, thorough and appropriate assessment;
- Provided by a registered practitioner, qualified to diagnose the condition;
- Supportive of the accommodations being considered or requested.
- Outlining the functional limitations of the disability impacting academics

Therefore, all relevant sections must be completed carefully and objectively to ensure accurate assessment of the student's disability-related needs, which may include access to support services, government and school bursaries, on-campus residence and academic accommodations while attending Post-secondary School.
The provision of all reasonable accommodations and services is assessed based on the current impact of the disability on academic performance. Please note, a diagnosis alone does not automatically mean accommodation is required.

***For a Learning Disability, ADHD and/or Autism Spectrum Disorder diagnosis**, a valid and recent psycho-educational assessment must be provided for academic accommodations.

Approved Professionals
The following persons who are licensed to practice in the Province of Ontario may complete this form:

- Family Physician
- Medical Specialist
- Psychiatrist
- Psychologist
- Optometrist
- Audiologist
- Ophthalmologist
- Speech-Language Pathologist
- Psychological Associate

Since this form contains many sections, professionals are asked to complete only those section(s) that relate to their scope of practice.

Part 1: Student Information

Student Name: _____

1. How long have you provided service to this student? _____

2. Last date of clinical assessment? _____

3. Will you continue to provide service(s) to the student while he/she attends Tyndale?
☐yes ☐no ☐unknown

The following criterion must be met:
The student experiences functional limitations due to a health condition that impairs the student's academic functioning at a learning and/or access level while pursuing post-secondary studies.

I confirm that:

a. this student has a disability based on a diagnosed* health condition according to the criterion outlined above, ☐ yes ☐ no or
b. I am monitoring this student's condition to determine a diagnosis ☐ yes ☐ no

Part 2: Confirmation of Disability

1. Please indicate the appropriate statement for this student in the current academic setting:

☐ Permanent disability with on-going (chronic or episodic) symptoms—**that will significantly impact the student over the course of his/her expected life**.
The Canadian Student Loan program defines a permanent disability as "a functional limitation caused by a physical or mental impairment that restricts the ability" of a student "to perform the daily activities necessary to participate in studies at a post-secondary level or the labour force and is expected to remain with a student for his/her "expected life". (DD. Gov. of Can. Section 4.5, 2003).
To designate a permanent disability, an evaluation has been conducted that involved the use of assessment tools/techniques that examined the functional impact of the disability as well as the permanence of the observed/assessed limitations.

☐ Temporary disability with anticipated duration:

a. From ___/___/___ to ___/___/___ (day, month, year); or

b. Unknown: please indicate reasonable duration for which s/he should be accommodated and/or supported at this time (please specify number of weeks/months): _____

2. Please complete the chart below to indicate:

a. **Diagnosis: Complete only if the student provides consent (complete only if consent is given in section 1 of this document)** - Include ongoing medical, physical, and/or mental health diagnosis (name or nature of the disability, disease, or syndrome).

b. **Prognosis** - expected duration.

Diagnoses	Prognosis

Part 3: Impact(s) on Academic Functioning

Please specify all applicable functional limitation(s); their severity (based on the scale below, i.e. 4 = the student cannot perform the task independently); and list the specific impact on academic functioning

SCALE

0	1	2	3	4
Unable to assess or unknown at this time	**Within normal limits** No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area

Functional Limitations	**Severity**	**Impact(s) on Academic Functioning**
Example: Writing	0 1 **2** 3 4	*Student unable to write for longer than 30 min. due to flare in arthritis pain.*
Example: Attention & concentration	0 1 2 **3** 4	*Student loses focus after 15 minutes of sustained attention, sensitive to distraction in the environment, difficulty completing assignments on time*
Example: Managing a full course load	0 1 **2** 3 4	*Unable to keep up with readings and assignments for 4 or more courses*
Section A: Cognitive Abilities	*To be completed by one of the following: Family Physician, Medical Specialist, Psychiatrist, Psychologist, Psychological Associate (if applicable for the disability diagnosis)*	
Attention/Concentration	0 1 2 3 4	
Short-term Memory	0 1 2 3 4	
Long-term Memory	0 1 2 3 4	
Information Processing	0 1 2 3 4	
Manage Distractions	0 1 2 3 4	
Executive Functioning	0 1 2 3 4	
Judgement	0 1 2 3 4	
Communication	0 1 2 3 4	
Other *(please describe)* _____	0 1 2 3 4	
Section B: Academic Abilities	*To be completed by one of the following: Family Physician, Medical Specialist, Psychiatrist, Psychologist, Psychological Associate (if applicable for the disability diagnosis)*	
Reading	0 1 2 3 4	
Writing	0 1 2 3 4	
Typing	0 1 2 3 4	
Listening	0 1 2 3 4	
Speaking	0 1 2 3 4	
Attend classes regularly	0 1 2 3 4	
Manage a full course load	0 1 2 3 4	
Other *(please describe)* _____	0 1 2 3 4	

Form based on the Ministry of Advanced Education and Skills Development (formerly called the Ontario Ministry of Training, Colleges, and Universities) Mental Health Innovation Fund Best Practices and Recommendations Documentation Requirements for Students with Disabilities excluding Learning Disabilities and ADHD

Part 3: Impact(s) on Academic Functioning *(continued)*

Please specify all applicable functional limitation(s); their severity (based on the scale below, i.e. 4 = the student cannot perform the task independently); and list the specific impact on academic functioning

SCALE

0	1	2	3	4
Unable to assess or unknown at this time	**Within normal limits** No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area

Functional Limitations	**Severity**	**Impact(s) on Academic Functioning**
Example: Writing	0 1 2 3 4	*Student unable to write for longer than 30 min. due to flare in arthritis pain.*
Example: Attention & concentration	0 1 2 3 4	*Student loses focus after 15 minutes of sustained attention, sensitive to distraction in the environment, difficulty completing assignments on time*
Example: Managing a full course load	0 1 2 3 4	*Unable to keep up with readings and assignments for 4 or more courses*
Section C: Physical Abilities		*To be completed by one of the following: Family Physician, Medical Specialist, Psychiatrist, Psychologist, Psychological Associate (if applicable for the disability diagnosis)*
Mobility	0 1 2 3 4	
Gross Motor	0 1 2 3 4	
Fine Motor/Manual Dexterity	0 1 2 3 4	
Stamina/Ability to engage in academic activities	0 1 2 3 4	
Sit for sustained period of time *e.g. 1-hour lecture*	0 1 2 3 4	
Stand for sustained period of time	0 1 2 3 4	
Lifting over 5lbs	0 1 2 3 4	
Maintain coordination	0 1 2 3 4	
Other *(please describe)* _____	0 1 2 3 4	
Section D: Social-Emotional Abilities		*To be completed by one of the following: Family Physician, Medical Specialist, Psychiatrist, Psychologist, Psychological Associate (if applicable for the disability diagnosis)*
Effectively control emotions during routine academic interactions	0 1 2 3 4	
Effectively read social cues	0 1 2 3 4	
Effectively control emotions during evaluation situations	0 1 2 3 4	

Form based on the Ministry of Advanced Education and Skills Development (formerly called the Ontario Ministry of Training, Colleges, and Universities) Mental Health Innovation Fund Best Practices and Recommendations Documentation Requirements for Students with Disabilities excluding Learning Disabilities and ADHD

Part 3: Impact(s) on Academic Functioning *(continued)*

Please specify all applicable functional limitation(s); their severity (based on the scale below, i.e. 4 = the student cannot perform the task independently); and list the specific impact on academic functioning

SCALE

0	1	2	3	4
Unable to assess or unknown at this time	**Within normal limits** No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area

Functional Limitations	**Severity**	**Impact(s) on Academic Functioning**
Example: Writing	0 1 2 3 4	*Student unable to write for longer than 30 min. due to flare in arthritis pain.*
Example: Attention & concentration	0 1 2 3 4	*Student loses focus after 15 minutes of sustained attention, sensitive to distraction in the environment, difficulty completing assignments on time*
Example: Managing a full course load	0 1 2 3 4	*Unable to keep up with readings and assignments for 4 or more courses*
Section D: Social-Emotional Abilities Continued		*To be completed by one of the following: Family Physician, Medical Specialist, Psychiatrist, Psychologist, Psychological Associate (if applicable)*
Ability to effectively manage the demands of academic life	0 1 2 3 4	
Participate appropriately during in-class and group work situations	0 1 2 3 4	
Ability to respond to change effectively	0 1 2 3 4	
Stress Management	0 1 2 3 4	
Other *(please describe)* _____	0 1 2 3 4	
Section E: Vision	*To be completed by one of the following: Family Physician, Optometrist, Ophthalmologist (if applicable)*	
Vision (*Visual acuity loss (best corrected), left eye, right eye, bilateral, visual field limitations)*	0 1 2 3 4	
Other *(please describe)* _____	0 1 2 3 4	

Form based on the Ministry of Advanced Education and Skills Development (formerly called the Ontario Ministry of Training, Colleges, and Universities) Mental Health Innovation Fund Best Practices and Recommendations Documentation Requirements for Students with Disabilities excluding Learning Disabilities and ADHD

Part 3: Impact(s) on Academic Functioning *(continued)*

Please specify all applicable functional limitation(s); their severity (based on the scale below, i.e. 4 = the student cannot perform the task independently); and list the specific impact on academic functioning

SCALE

0	1	2	3	4
Unable to assess or unknown at this time	**Within normal limits** No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area

Functional Limitations	**Severity**	**Impact(s) on Academic Functioning**
Example: Writing	0 1 2 3 4	*Student unable to write for longer than 30 min. due to flare in arthritis pain*
Example: Attention & concentration	0 1 2 3 4	*Student loses focus after 15 minutes of sustained attention, sensitive to d in the environment, difficulty completing assignments on time*
Example: Managing a full course load	0 1 2 3 4	*Unable to keep up with readings and assignments for 4 or more courses*
Section F: Hearing	*To be completed by one of the following: Family Physician, Audiologist (if applicable)*	
Hearing	0 1 2 3 4	
Participate appropriately during in-class and group work situations	0 1 2 3 4	
Other *(please describe)* _____	0 1 2 3 4	
Section G: Speech	*To be completed by one of the following: Family Physician, Speech and Language Pathologist (if applicable)*	
Speech	0 1 2 3 4	
Other *(please describe)* _____	0 1 2 3 4	
Section H: Safety	*To be completed by one of the following: Family Physician, Medical Specialist*	

Does this student have a condition such that Tyndale University College & Seminary may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork, (e.g. seizure disorder, severe allergic reaction) ☐ yes ☐ no

If Yes, please describe the condition(s) and its impact on academic functioning:

Form based on the Ministry of Advanced Education and Skills Development (formerly called the Ontario Ministry of Training, Colleges, and Universities) Mental Health Innovation Fund Best Practices and Recommendations Documentation Requirements for Students with Disabilities excluding Learning Disabilities and ADHD

Please use this space to provide any further rationale to explain/list the student's functional limitations related to academic performance:

For hearing impairment, please also include your most recent Audiogram; For a Learning Disability, ADHD and/or Asperger's diagnosis, a valid and recent psycho-educational assessment must be provided.

Part 4: Treatment

1. Medication(s)? ☐yes ☐no ☐n/a
    a. If yes, when is the medication likely to affect academic functioning negatively? *(Click all that apply)*
        ☐Morning
        ☐Afternoon
        ☐Evening
        ☐N/A
    b. If yes, what are the potential academic impact(s) of medication(s):

2. Treatment(s) and/or support(s)—*Examples: counseling, psychotherapy, massage therapy, etc.*

Current:

Recommended:

Part 5: Accommodation, Specialized Equipment and Services Recommendations *

*The Accessibility Services office will also determine any appropriate accommodation(s) based on Part 3.

Based on the functional limitations you identified in Part 3, is there a need for specialized equipment and/or services? ☐yes ☐no

If the answer is "yes", please select items and provide a rationale as to why the specialized equipment or service is needed.

Recommendation *(please check as applicable)*	**Rationale**
Specialized Services	
☐ **Sign Language Interpreter**	
☐ **Computerized Note-taker**	
☐ **Documents in Braille**	
☐ **Large print**	
☐ **Accessible textbooks/ readings**	
☐ **Communication Access Real-time Translation (CART)**	
☐ **Other** *(please specify)* _____	

Part 5: Accommodation, Specialized Equipment and Services Recommendations * *Continued*
*The Accessibility Services office will also determine any appropriate accommodation(s) based on Part 3.

Recommendation ***(please check as applicable)***	**Rationale**
Class Modifications	
☐ **Ergonomic Furniture**	
☐ **Specialized Lighting**	
☐ **Assigned Seating**	
☐ **Other** *(please specify)* _____	
Assistive Technology/ies	
☐ **Use of a Screen Reader**	
☐ **Text to Speech Software**	
☐ **Speech to Text Software**	
☐ **Amplification System**	
☐ **Magnification System**	
☐ **Video Captioning**	
☐ **Laptop**	
☐ **Other** *(please specify)* _____	
Personal Equipment	
☐ **Manual wheelchair**	
☐ **Automated wheelchair**	
☐ **Motorized scooter**	
☐ **Walker**	
☐ **Assistive cane**	
Care	
☐ **Personal Care Attendant***	
*Attendant or personal care workers are not coordinated by Tyndale. Tyndale must coordinate their own service providers	
☐ **Service Animal**	
A "service animal" is defined as any animal specifically trained to perform tasks for the benefit of an individual with a disability, including, but not limited to, guiding persons with restricted vision, alerting those who have hearing losses to the presence if intruders, pulling a wheelchair, or fetching dropped items. **Students must abide by the animal policy and have part 6 of this form completed by a regulated healthcare professional**	
Accommodations (please list any additional as appropriate)	

Form based on the Ministry of Advanced Education and Skills Development (formerly called the Ontario Ministry of Training, Colleges, and Universities) Mental Health Innovation Fund Best Practices and Recommendations Documentation Requirements for Students with Disabilities excluding Learning Disabilities and ADHD

Please attach any relevant information to assist with this student's academic accommodation

Part 6: Animals on Campus

A regulated healthcare professional is required to complete the medical portion of this section if a service animal is identified as an appropriate accommodation. *Documentation for a Service Dog is only required if the student's disability and its limitations are not obviously apparent.*

STUDENTS MUST COMPLY WITH THE ANIMALS ON CAMPUS POLICY

I: Proposed Animal Information *(completed by the student)*

Name:_____ Type of Animal:_____ Age:_____

II: Service Animal Verification *(completed by a medical practitioner only if the student's disability and its limitations are not obviously apparent)*

1. According to your medical diagnoses, does the student require a service animal? ☐ Yes ☐ No

2. What is the disability related need for the service animal? *(please specify)*_____

   _____

   _____

3. What is the use of the service animal? *(please check as appropriate)*

- ☐ Be an emotional or physical anchor by offering a calming effect when sensory stimulus is heightened
- ☐ Alert partner to possible dangers
- ☐ Serve as a travel aid
- ☐ Alert individual of specific sounds
- ☐ Retrieve or prompt the person to take medication
- ☐ Warn or provide aid during medical conditions
- ☐ Retrieve or activate need for medical attention
- ☐ Guide partner out of crowds
- ☐ Help with mobility difficultues

☐ Other:_____

III: Animal Care *(Completed by the regulated healthcare professional)*

1. Have you discussed the responsibilities associated with properly caring for an animal while engaged in typical post-secondary activities?

   ☐ Yes ☐ No

2. Do you believe those responsibilities might exacerbate the student's symptoms in any way? ☐ Yes ☐ No

   a. If yes, please specify_____

_____

Part 7: Certified Practitioner Information

I, hereby confirm that this form is based on the examination and clinical assessment of the above student and by signing the form it's acknowledged that the assessment falls into my legislated scope of practice in the province of Ontario.

Practitioner's Name (please print): _____

Signature: _____ Date: _____

Professional Designation: _____ License/Registration Number: _____

Facility Name and Address:

Office stamp (or business card or copy letterhead):

Thank you for taking the time to complete this form—the information will facilitate the supports requested by your client while at Tyndale